North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

SHIGELLOSIS
Confidential Communicable Disease Report—Part 2
NC DISEASE CODE: 39

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS

Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Fever ☐Y ☐N ☐U
Highest measured temperature_____
Fever onset date (mm/dd/yyyy):____/____/____
How taken: _____
Chills or rigors ☐Y ☐N ☐U
Nausea ☐Y ☐N ☐U
Vomiting ☐Y ☐N ☐U
Abdominal pain or cramps ☐Y ☐N ☐U
Diarrhea ☐Y ☐N ☐U
Describe (select all that apply)
☐ Bloody
☐ Non-bloody
☐ Watery
☐ Other
Maximum number of stools in a 24-hour period:_____
Bacteremia ☐Y ☐N ☐U
If yes, date of positive blood culture (mm/dd/yyyy):____/____/____
Other symptoms, signs, clinical findings, or complications consistent with this illness? ☐Y ☐N ☐U
If yes, specify: _____
Is patient in child care? ☐Y ☐N ☐U
Name of care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Contact name:_____
Telephone: (_____) _____

Patient wears diapers or shares a classroom with diapered children? ☐Y ☐N ☐
Who wears diapers?
☐ Patient ☐ Classmate
Give names of all child health care arrangements attended by the patient that involve diapering (patient wears diapers or other children in the same group wear diapers).
_____
_____
Is patient a child care worker or volunteer in child care? ☐Y ☐N ☐U
Name of child care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Contact name:_____
Telephone: (_____) _____
Is patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U
Name of child care provider: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Contact name:_____
Telephone: (_____) _____
Is patient a student? ☐Y ☐N ☐U
Type of school:
☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College/College/University
☐ Other academic institution (i.e. trade school, professional school, etc)
Name: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Contact name:_____
Telephone: (_____) _____
Specify grade: _____
Is patient a school WORKER / VOLUNTEER in NC school setting? ☐Y ☐N ☐U
Type of school
☐ NC Public School (preK-12)
☐ NC Private School (preK-12)
☐ Other School (preK-12)
☐ Community College/College/University
☐ Other academic institution (i.e. trade school, professional school, etc)
Name: _____
Address: _____
City:_____State: _____
Zip code:_____County: _____
Telephone: (_____) _____

Notes:

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						SSN

PREDISPOSING CONDITIONS

Any immunosuppressive conditions? ☐Y ☐N ☐U

Specify:

REASON FOR TESTING

Why was the patient tested for this condition?

- ☐ Symptomatic of disease
- ☐ Screening of asymptomatic person with reported risk factor(s)
- ☐ Exposed to organism causing this disease (asymptomatic)
- ☐ Household/close contact to a person reported with this disease
- ☐ Other, specify_____
- ☐ Unknown

TREATMENT

Did patient take an antibiotic as treatment for this illness? ☐Y ☐N ☐U

Specify antibiotic name:

_____

Date anitbiotic began (mm/dd/yyyy):____/____/____

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U

Hospital name: _____

City, State:_____

Hospital contact name: _____

Telephone: (_____) _____ - _____

Admit date (mm/dd/yyyy): ____/____/____

Discharge date (mm/dd/yyyy):____/____/____

ISOLATION/QUARANTINE/CONTROL MEASURES

Restrictions to movement or freedom of action? ☐Y ☐N

Check all that apply:

- ☐ Work
- ☐ Child care
- ☐ School
- ☐ Sexual behavior
- ☐ Blood and body fluid
- ☐ Other, specify

_____

Date control measures issued:____/____/____

Date control measures ended:____/____/____

Was patient compliant with control measures? ☐Y ☐N

Did local health director or designee implement additional control measures? (example: cohort classrooms, special cleaning, active surveillance, etc.)☐Y ☐N

If yes, specify: _____

_____

Were written isolation orders issued? ☐Y ☐N

If yes, where was the patient isolated? _____

_____

Date isolation started: ____/____/____

Date isolation ended: ____/____/____

Was the patient compliant with isolation? ☐Y ☐N

Were written quarantine orders issued? ☐Y ☐N

If yes, where was the patient quarantined?

_____

Date quarantine started: ____/____/____

Date quarantine ended: ____/____/____

Was the patient compliant with quarantine? ☐Y ☐N

BEHAVIORAL RISK & CONGREGATE LIVING

During the 7 days prior to onset of symptoms, did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? ☐Y ☐N ☐U

Name of facility:_____

Dates of contact:

From _____/_____/_____ to _____/_____/_____

During the 7 days prior to onset of symptoms, did the patient attend social gatherings or crowded settings? ☐Y ☐N ☐U

If yes, specify:_____

In what setting was the patient most likely exposed?

- ☐ Restaurant
- ☐ Home
- ☐ Work
- ☐ Child Care
- ☐ School
- ☐ University/College
- ☐ Camp
- ☐ Doctor's office/ Outpatient clinic
- ☐ Hospital In-patient
- ☐ Hospital Emergency Department
- ☐ Laboratory
- ☐ Long-term care facility /Rest Home
- ☐ Military
- ☐ Prison/Jail/Detention Center
- ☐ Place of Worship
- ☐ Outdoors, including woods or wilderness
- ☐ Athletics
- ☐ Farm
- ☐ Pool or spa
- ☐ Pond, lake, river or other body of water
- ☐ Hotel / motel
- ☐ Social gathering, other than listed above
- ☐ Travel conveyance (airplane, ship, etc.)
- ☐ International
- ☐ Community
- ☐ Other (specify)

_____

- ☐ Unknown

CLINICAL OUTCOMES

Discharge/Final diagnosis:_____

_____

Survived? ☐Y ☐N ☐U

Died? ☐Y ☐N ☐U

Died from this illness? ☐Y ☐N ☐U

Date of death (mm/dd/yyyy):_____/_____/_____

TRAVEL/IMMIGRATION

The patient is:

- ☐ Resident of NC
- ☐ Resident of another state or US territory
- ☐ Foreign Visitor
- ☐ Refugee
- ☐ Recent Immigrant
- ☐ Foreign Adoptee
- ☐ None of the above

Did patient have a travel history during the 7 days prior to onset of symptoms? ☐Y ☐N ☐U

List travel dates and destinations:

From _____/_____/_____ to _____/_____/_____

_____

_____

Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐Y ☐N ☐U

List persons and contact information:

_____

_____

_____

Additional travel/residency information:

OTHER EXPOSURE INFORMATION

Does the patient know anyone else with similar symptoms? ☐Y ☐N ☐U

If yes, specify:

During the 7 days prior to onset of symptoms did the patient have contact with sewage or human excreta? ☐Y ☐N ☐U

FOOD RISK AND EXPOSURE

During the 7 days prior to onset of symptoms did the patient eat any raw or undercooked seafood or shellfish (i.e., raw oysters, sushi, etc.)? ☐Y ☐N ☐U

Specify type of seafood/shellfish_____

Specify place of exposure_____

Describe the source of drinking water used in the patient's home (check all that apply)**:**

- ☐ Bottled water supplied by a company
- ☐ Bottled water purchased from a grocery store
- ☐ Municipal supply (city water)
- ☐ Well water

Does the patient have a water softener or water filter installed inside the house to treat their water? ☐Y ☐N ☐U

During the 7 days prior to onset of symptoms, did the patient drink any bottled water? ☐Y ☐N ☐U

Specify type/brand _____

Where does the patient/patient's family typically buy groceries?

Store name:_____

Store city: _____

Shopping center name/address:

_____

During the 7 days prior to onset of symptoms, did the patient:

Eat any food items that came from a produce stand, flea market, or farmer's market? ☐Y ☐N ☐U

Specify source: _____

Eat any food items that came from a store or vendor where they do not typically shop for groceries? ☐Y ☐N ☐U

Specify source(s): _____

During the 7 days prior to onset of symptoms, was the patient:

Employed as food worker? ☐Y ☐N ☐U

Where employed?_____

Specify job duties:_____

What dates did the patient work?

From _____/_____/_____ to _____/_____/_____

Employed as food worker while symptomatic? ☐Y ☐N ☐U

Where did the patient work? _____

What dates did the patient work?

From _____/_____/_____ to _____/_____/_____

What day did the patient return to food service work?

Date: _____

Where did patient return to work?_____

CONTINUED ON NEXT PAGE

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
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FOOD RISK AND EXPOSURE (CONTINUED)

During the 7 days prior to onset of symptoms, was the patient: Non-occupational food worker (e.g. potlucks, receptions) during contagious period**?** ..... ☐Y ☐N ☐U

Where employed?_____

Specify dates worked during contagious period:

From _____/_____/_____ to _____/_____/_____

Health care worker or child care worker handling food or medication in the contagious period ?..... ☐Y ☐N ☐U

Where employed?_____

Specify dates worked during contagious period:

From _____/_____/_____ to _____/_____/_____

During the 7 days prior to onset of symptoms, did the patient:

Handle/eat shellfish (i.e. clams, crab, lobster, mussels, oysters, shrimp, crawfish, other shellfish)**?**..... ☐Y ☐N ☐U

Eat raw fruit?..... ☐Y ☐N ☐U

Specify raw fruit:

- ☐ Apples
- ☐ Bananas
- ☐ Oranges
- ☐ Grapes, specify:_____
- ☐ Pears
- ☐ Peaches
- ☐ Berries, specify_____
- ☐ Melon,specify_____
- ☐ Mangoes
- ☐ Other, specify: _____

Eat raw salads or vegetables other than sprouts?..... ☐Y ☐N ☐U

Specify raw salad or vegetable:

- ☐ Bagged salad greens without toppings, type: _____
- ☐ Salad with toppings, specify: _____
- ☐ Lettuce, type: _____
- ☐ Spinach
- ☐ Tomatoes, type: _____
- ☐ Cucumbers
- ☐ Mushrooms, type: _____
- ☐ Onions, type: _____
- ☐ Potatoes, type:_____
- ☐ Other, specify: _____

Eat sprouts?..... ☐Y ☐N ☐U

Specify type of sprouts:

☐ Alfalfa ☐ Clover ☐ Bean

- ☐ Other, specify: _____
- ☐ Unknown

Eat fresh herbs? ..... ☐Y ☐N ☐U

Specify:

☐ Basil ☐ Thyme
☐ Parsley ☐ Cilantro
☐ Oregano ☐ Rosemary
☐ Cumin

- ☐ Other, specify: _____

Eat at a group meal? ..... ☐Y ☐N ☐U

Specify:

- ☐ Place of Worship
- ☐ School
- ☐ Social function
- ☐ Other, specify:_____

Eat food from a restaurant? ..... ☐Y ☐N ☐U

Name:_____

Location:_____

Notes:

WATER EXPOSURE

During the 7 days prior to onset of symptoms, did the patient have recreational, occupational, or other exposure to water, including aerosolized water in household, community or health care settings? ..... ☐Y ☐N ☐U

Activity(ies):

- ☐ Playing, wading, splashing
- ☐ Swimming
- ☐ Other, specify_____

Notes:

CASE INTERVIEWS/INVESTIGATIONS

Was the patient interviewed?..... ☐Y ☐N ☐U

Date of interview (mm/dd/yyyy):_____/_____/_____

Were interviews conducted with others?..... ☐Y ☐N ☐U

Who was interviewed?

Were health care providers consulted?..... ☐Y ☐N ☐U

Who was consulted?

Medical records reviewed (including telephone review with provider/office staff)? ..... ☐Y ☐N ☐U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

GEOGRAPHICAL SITE OF EXPOSURE

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

☐ In NC

City _____

County_____

☐ Outside NC, but within US

City _____

State _____

County_____

☐ Outside US

City _____

Country _____

☐ Unknown

Is the patient part of an outbreak of this disease? ..... ☐Y ☐N ☐U

Notes:

Shigellosis *(Shigella spp.)*

2005 CDC Case Definition

Clinical description

An illness of variable severity characterized by diarrhea, fever, nausea, cramps, and tenesmus. Asymptomatic infections may occur.

Laboratory criteria for diagnosis

- Isolation of *Shigella* from a clinical specimen

Case classification

Probable: a clinically compatible case that is epidemiologically linked to a confirmed case.

Confirmed: a case that meets the laboratory criteria for diagnosis. When available, O antigen serotype characterization should be reported.

Comment

For users of the legacy National Electronic Telecommunications System for Surveillance (NETSS), laboratory-confirmed isolates are also reported via the Public Health Laboratory Information System (PHLIS), which is managed by the Foodborne and Diarrheal Diseases Branch, Division of Bacterial and Mycotic Diseases, National Center for Infectious Diseases, CDC. The National Electronic Disease Surveillance System (NEDSS) or NEDSS compatible systems will eventually replace PHLIS; users of NEDSS or compatible systems which report to CDC should not report via PHLIS.

Both asymptomatic infections and infections at sites other than the gastrointestinal tract, if laboratory confirmed, are considered confirmed cases that should be reported.